EXHIBIT "J"

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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BENITO RODRIGO FAJARDO TARQUI and
LUIS A. FARJARDO, as Administrators of the
Estate of MARIA T. QUIRIDUMBAY, Deceased,

Affidavit

Plaintiffs,

-against-

UNITED STATES OF AMERICA,

Defendant.

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State of FLORIDA)
County of MIAMI DADE) .:ss

MICHAEL M. BEGMAN, MD, being duly sworn, deposes and says:

I aver that the opinions set forth in my reports dated June 1, 2015 and January 2, 2016, are true and correct within a reasonable degree of medical certainty. The contents of the reports are incorporated herein by reference.

MICHAEL M. BERGMAN, MD

Sworn to before me this
Day of ~~October~~ NOVEMBER, 2016
NOVEMBER 2ND 2016

LUIS ALFREDO VIGANEGO

MICHAEL M. BERGMAN, MD

LUIS ALFREDO VIGANEGO
Notary Public, State of Florida
Commission# FF 189946
My comm. expires Jan. 14, 2019

June 1, 2015

RE: Maria Quiridumbay

To Whom It May Concern:

I am a Board Certified Infectious Disease subspecialist as well as an Internal Medicine specialist and have been asked to review the medical records of Maria Quiridumbay formerly of the Peekskill, NY area and now deceased. These records spanned from December 11, 2009 to July 29, 2010 which was the date of Maria Quiridumbay's death. Also included for my review was the deposition of Dr. Chung as well as the hospital records of Baby Girl Quiridumbay during her perinatal period including her protracted hospital stay that immediately followed her birth.

A summary of this case follows.

1) Maria Quiridumbay was 35 years of age on December 11, 2009 when she began to experience diffuse aches while she was pregnant. Maria was evaluated by Dr. Portchester who prescribed prednisone, a corticosteroid. A work-up was initiated that culminated in the diagnosis of Rheumatoid Arthritis.
2) Maria was admitted to the Hudson Valley Hospital on July 13, 2010 in labor. Later that day she vaginally delivered a baby girl that required NICU (neonatal ICU) care due to "sepsis". The records are quite clear that the sepsis in the baby began with the Mother who developed fever to 101.9 degrees with an elevated white blood cell count and a leftward shift on July 13-14, 2010. Indeed, blood cultures that were drawn from Maria on July 13, 2010 became positive prior to the patient's discharge on July 15, 2010. In a progress note from July 15, 2010, a nurse named Stephanie Hutchings documented at 703AM that the patient had positive blood cultures and "day staff to notify HRHC provider". At the same time as the blood cultures were positive, a genital culture grew the same organism, i.e. group A streptococcus.
3) The bacteria that caused this patient's blood and genital cultures to be positive is also known as the "killer strep". This bacteria is renowned for being potentially lethal and very fast-paced in its destruction. For these reasons, it is the standard of care to treat patients with this bacteria in their blood with an antibiotic for 10-14 days, usually by the intravenous route. It is also customary to address the source of the "blood poisoning" (bacteremia) with imaging tests as well as an Obstetrical consultation to rule out feared complications such as endometritis, an inflammation and infection of the uterine lining that can complicate a delivery.
4) Neither aggressive antibiotic therapy nor appropriate imaging tests such as an ultrasound nor an Obstetric consultation were ordered for this patient who was actually discharged on July 15, 2010 with signs and symptoms consistent with endometritis. However, antibiotic therapy was briefly administered (cefazolin and clindamycin) but only for a single day (July 14, 2010) and was then discontinued

when an erroneous diagnosis of Rheumatoid Arthritis was given to this patient as a full explanation for her elevated white blood cell count with fever.

5) Maria returned to the Emergency Ward of Hudson Valley Hospital on July 26, 2010 with diffuse aches. She was administered Tylenol and a narcotic (vicodin).
6) Maria returned to the EW on July 28, 2010 with similar complaints and was again given pain medications. Later that day Maria was seen at home by her Visiting Nurse who noted the patient's temperature was low. The Visiting Nurse urged that Maria return to an EW. When she presented to the Westchester Medical Center, Maria Quiridumbay was lethargic and pus was noted to be present at the cervical opening, consistent with the diagnosis of streptococcal endometritis. Unfortunately, despite the best efforts at the Westchester Medical Center Maria died of her infection the following day.

Discussion:

Maria Quiridumbay died of undertreatment of her bacteremia that was present on July 13, 2010. When a postpartum patient has streptococci in the blood, aggressive, prolonged use of appropriate anti-streptococcal antibiotic therapy is mandatory, along with addressing the source of this infection. None of these crucial steps were performed here and the patient died approximately two weeks later of endometritis.

In his deposition, Dr. Chung made several glaring errors. While Dr. Chung admitted that the patient's elevated white blood cell count could have been due to infection or inflammation or the effect of steroids, he failed to mention that this patient had a large left shift on her differential (30 plus bands) which is never seen with inflammation nor steroid use. He also failed to mention that this patient had several positive blood cultures that were never treated on the July 13, 2010 hospitalization. Dr. Chung also admitted that he didn't even know that Baby Girl Quiridumbay had required a protracted hospitalization as she was born septic (infected) presumably due to the maternal bacteremia/endometritis.

It can be stated, within a reasonable degree of certainty that the Hudson Valley Hospital was negligent in discharging Maria Quiridumbay on July 15, 2010 with recent fevers, leukocytosis (white blood cell count elevation) and left shift in the absence of antibiotic therapy. Similarly, the failure of antibiotic therapy to be administered continued even after Nurse Hutchings supposedly communicated the presence of positve blood cultures to the HRHC provider on July 15, 2010.

Even when Maria Quiridumbay returned to the EW on July 26 and July 28, 2010 no caretaker took an accurate history that should have established the presence of this undertreated bacteremic endometritis. This responsibility was shared by multiple individuals including Drs. Gar, Chung and the hospital as well as its allied personnel such as the hospital PA Lindsay Aarsted.

It is my opinion that, as late as the July 26, 2010 EW visit and possibly even later, had appropriate intravenous antibiotic and surgical therapies been administered, Maria Quiridumbay would have survived and been able to continue to care for her husband and daughter.

All statements made are done within a reasonable degree of medical certainty.

Please do not hesitate to contact me if further assistance is needed.

Very truly yours,

Michael M. Bergman, MD

MMB/msb

January 2, 2016

RE: Maria Quiridumbay, deceased

Dear Attorney Friedman,

I have reviewed the depositions that were recently submitted in the above-captioned matter. This report will serve to supplement my earlier report that was dated June 1, 2015.

The depositions of Drs.Rashmi Kar, Sachin Shah, nurse midwife Ingrid Deler-Garcia and Nurse Lindsay Seekircher were all taken following my earlier report but none of these depositions materially affected my earlier findings and conclusions. Salient highlights from these newly reviewed depositions are summarized.

1) Dr. Rashmi Kar, an Obstetrician was indeed aware that Maria Quiridumbay suffered from rheumatoid arthritis, an autoimmune, immune suppressive disorder and that the patient was receiving prednisone for that condition. Dr. Kar noted in her deposition that he was contacted by Janet Brooks, a nurse midwife at that Maria began to have fever on her second postpartum day (July 15, 2010) while at Hudson Valley Hospital. Dr. Kar ordered that cultures of blood, urine and vaginal secretions be obtained as well as beginning empiric antibiotics.
2) Dr. Sara Jordan was the on-call physician that day and a decision was made to stop antibiotic therapy. No Infectious Disease consultation was obtained, not by Dr. Kar nor by Dr. Jordan despite blood and vaginal cultures growing a streptococcal species. Dr. Kar was aware both of the patient's rheumatoid arthritis, her recent prednisone therapy, the positive vaginal as well as the positive vaginal cultures. Despite this highly suggestive scenario for the clinical diagnosis of endometritis in a compromised patient, Drs. Kar and Jordan allowed this potentially fatal condition to continue unchecked off of intravenous antibiotic therapy and in the absence of further examination or imaging to search for endometritis.
3) On July 26, 2010 Dr. Kar was contacted by Dr. Chung, an Emergency Ward physician due to the onset of multiple joint complaints that the patient had begun to experience. During that EW visit, toradol and vicodin and other medications were given, some of which may suppress the ability of a patient to mount a fever. In addition, Maria's white blood cell count was over 20,000 (more than twice normal) and she had a left shift on her CBC which is entirely consistent with

infection and virtually no other inflammatory condition was conceivable at that time.

4) Further, in his deposition, Dr. Kar admits that he never inquired as to the medical condition of the baby in this case who was ill with sepsis (severe infection) early in the neonatal period.
5) Another criticism of Dr. Kar focuses on the admission in his deposition (page 49) that endometritis was on his differential diagnosis of an ill postpartum woman with fever, positive vaginal and blood cultures, yet no further examination or imaging studies were done and antibiotic therapy was discontinued very prematurely for this potentially fatal condition.

6) Dr. Sachin Shaw is an Emergency Room physician who erroneously concluded that since Maria Quiridumbay didn't have fever (this is refuted by the facts) and had multiple joints involved in her July 26th presentation, that infection was essentially ruled out. His deposition is also replete with other misunderstandings such as the failure to appreciate that the elevated white blood cell count that this patient evidenced, along with the leftward shifted differential were not suggestive of rheumatoid arthritis but could only be seen in undertreated or partially treated infection. Dr. Shah also failed to elicit the history of recent positive blood and vaginal cultures, as well as the history of the Quiridumbay Baby's sepsis. Dr, Sachin Shaw also placed undue significance on "trending" of labs and vital signs suggesting that a momentary improvement in an unstable patient's condition has predictive value that such a trend is likely to continue. This logic is seriously flawed in any condition, such as a partially treated bacteremia, that can wax and wane numerous times while still curable before becoming absolutely incurable.

7) The deposition of Ingrid Deller-Garcia, the midwife documented that she was aware that Maria had positive blood cultures as early as July 15, 2010 and that a physician was made aware.
8) The deposition of Lindsay Seekircher, RN also documented several of the prior comments already made and did not materially alter any conclusions made to date.

Conclusions that have been drawn in this report, as was true in the prior report, are entirely made within a reasonable degree of medical certainty. I again reserve the right to modify any opinions that have been made should additional medical records become available that calls prior fact into question or dispute.

Please feel free to contact me should additional questions arise.

Very truly yours,

Michael M. Bergman, MD

Michael M. Bergman, MD

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PROFESSIONAL EXPERIENCE	**Chief of Infectious Disease Division at Sturdy Memorial Hospital** Attleboro, MA (April, 1999 to April, 2016) **Chief of Infectious Disease Division at Whittier Rehabilitation Hospital** Westboro, MA (May, 1999 to April, 2016) **Chief of Infectious Disease Division at Kindred Hospital** North Shore, MA (June, 2002 to April, 2016)
POST DOCTORAL TRAINING	**Infectious Disease Fellow,** Saint Vincent Hospital Worcester, MA (1985-1987) **Chief Medical Resident,** Newton-Wellesley Hospital Newton, MA (1984-1985) **Medical Resident,** Newton-Wellesley Hospital Newton, MA (1983-1984)
EDUCATION	**Tufts University School of Medicine,** Boston, MA (1982) **University of Massachusetts,** Amherst, MA (1978) Bachelor of Science, Summa Cum Laude, Phi Beta Kappa
CLINCIAL RESEARCH EXPERIENCE	(1) Levofloxacin efficacy in community-acquired Pneumonia (begun 1998). (2) Saccharomyces boulardi vs. placebo for recurrent clostridia difficile colitis (2001-2002). (3) HA-1A vs. placebo-The role of anti-endotoxin antibodies in gram-negative septic shock (1990-1994). (4) Clinical Investigator- Intravenous Ciprofloxacin Study (1990). (5) Oral ciprofloxacin vs. ceftriaxone- Randomized, double-blind study in community-acquired pneumonia. (1991-1993, multicenter trial). (6) Intravenous cefonicid vs. intravenous cefuroxime- randomized, double-blind study in community-acquired pneumonia (1991-1993, multicenter trial). (7) Compassionate Use Investigator of HA-1A in gram-negative septicemia, a multicenter study (1992-1994). (8) Other smaller scale investigations (full listing available upon request).

TEACHING EXPERIENCE	**Assistant Professor of Medicine** University of Massachusetts Medical School Worcester, MA (1991 to 2016)
	Preceptor Massachusetts College of Pharmacy and Health Sciences Physician Assistant Program Worcester, MA (February, 2015)
	Visiting Attending Physician Milford-Whitinsville Regional Hospital Milford, MA (August 1998; October 1997; December, 1991 to January, 1992)
	Instructor: Physical Diagnosis Course University of Massachusetts Medical School Worcester, MA (1985-1996)
	Grand Rounds Speaker at multiple institutions on various Infectious Disease topics. (Full listing available upon request).
MEDICO-LEGAL AND PEER REVIEW EXPERIENCE	MedQuest Infectious Disease Consultant New York, NY (2004-present)
	Medical Advisory Tribunal, Northampton Superior Court North Hampton, MA (1997 to present)
	Acting Medical Director of Medical Review Foundation Vienna VA (April 1999 to present)
	Medical Quality Foundation, Vienna, VA (1990 to 1998)
LICENSURE/ CERTIFICATION	Diplomat Subspecialty of Infectious Disease Subspecialty Certification (1990)
	Recertifications in Infectious Disease subspecialty: November, 2000 to December, 2010 and April, 2011 to December 2021 (American Board of Internal Medicine)
	American College of Internal Medicine Board Certification (1985)
	Massachusetts License Registration #495969 (1985)
	Diplomat, National Board of Medical Examiners (1983)
PROFESSIONAL APPOINTMENTS	**President of the Medical Staff** Kindred Hospital, North Shore Peabody, MA (October, 2010 to June, 2014 term)
	Chairman, Infection Control Committee Sturdy Memorial Hospital, Attleboro, MA

(1999 to 2016)

Milford-Whitinsville Regional Hospital, Milford, MA (1987 to 1999)
Whittier Hospital, Westboro, MA (1997 to 2016)

Pharmacy and Therapeutics Committee
Sturdy Memorial Hospital (September 1999 to 2016)
Milford-Whitinsville Regional Hospital (1987 to 1999)
Whittier Hospital, Westboro, MA (1997 to 2016)

Reviewer, Archives of Internal Medicine (1987)

Infection Control Committee, Saint Vincent Hospital
Worcester, MA in charge of monthly antimicrobial updates (1985 to 1987)

PROFESSIONAL AFFILIATIONS

International Who's Who Among Professionals, (Selected 1995)

Who's Who in Medicine (Selected 1990)

National Association for the Advancement of Science (Nominated 1994)

Massachusetts Medical Society

Worcester District Medical Society

Diplomat, American College of Physicians

American Medical Association

PUBLICATIONS

(1) Bergman, M.M. Gagnon, D. and Doem, G.V., "Pichia Ohmeri Fungemia: A Case Report and Literature Review" Diagnosis Microbial Infection. Dis: 1998 Mar, 30 (3): 229-31.

(2) Bergman, M.M. and Ciak, C., "A Novel Approach to an Uncommon Condition," Hospital Practice: 1989; 24(8): 37-42.

(3) Bergman, M.M. and Glew, R.H., "Acute Interstitial Nephritis Associated with Vancomycin Therapy" Archives of Internal Medicine: 1998;148(10)2139-2140.

(4) Bergman, M.M. and Gleckman, R.A., "Infectious Complications in Alcohol Abusers" Hospital Practice: 1998;23(9):145-156.

(5) Gleckman, R.A. and Bergman, M.M., "Bacterial Pneumonia: Specific Diagnosis and Treatment of the Elderly" Geriatrics: 1987;42(9):29-41.

(6) Gleckman, R.A. and Bergman, M.M., "The Role of Newer Beta-Lactam Antibiotics in the Elderly, Part II" Geriatrics:1987;42(2):61-70.

(7) Bergman, M.M. and Gleckman, R.A., "Primary Meningococcal Pneumonia in the Elderly" Hospital Practice: 1987;22(5):29-33.

(8) Bergman, M.M. and Gleckman, R.A., "Heterophile-Negative Infectious Mononucleosis-Like Syndromes" Postgraduate Medicine:1987;81(1):313-326.

(9) Gleckman, R.A. and Bergman, M.M., "When to Turn to the Newer Penicillins and Beta-Lactams" Journal of Respiratory Diseases: 1986;7(11):99-109.

(10) Glecklman, R.A. and Bergman, M.M., "When to Turn to the Newer Cephalosporin Agents in Lower Respiratory Tract Infections" Journal of Respiratory Diseases: 1986;7(12):51-57.

(11) Gleckman, R.A. and Bergman, M.M., "Newer Clinical Applications for Older Antibiotics," Hospital Formulary: 1986;21(8):844-850.

(12) Gleckman, R.A. and Bergman, M.M., "Community-Acquired Urosepsis in Elderly Women," Geriatric Medicine Today: 1986;5(5):73-80.

(13) Gleckman, R.A. and Bergman, M.M., "Newer Antibiotics: Their Place in Geriatric Care, Part I," Geriatrics: 1986;41(12):51-55.